WORKERS COMPENSATION / LIABILITY FORM

PATIENT'S NAME: ____ DOB: _____ / _____ / _____

ADDRESS: ____SS#: ______ - ______ - _______

EMPLOYER: ____ PHONE: ___________________

EMPLOYER'S ADDRESS: ____

WHO CAN VERIFY THIS INFORMATION: ____

IS THIS CONDITION RELATED TO EMPLOYMENT? YES _____ NO _____

IF ACCIDENT: WORK: _____ OTHER: _____ DATE OF ILLNESS: _____ / _____ / _____

DATE OF FIRST CONSULTATION WITH ANY PHYSICIAN: _____/_____/_____

WHERE DID THE INJURY OCCUR? ____

____

DATES OF WORK MISSED DUE TO THIS ILLNESS/INJURY: ____________________________________

HOW DID THE INJURY OCCUR? ____

IN THE EVENT I FAIL TO PROPERLY COMPLETE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OF CONDITION OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THE ILLMESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSASTION CASE, I, ______________________, HEREBY AGREE TO PAY THE PHYSICIAN'S USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

DATE: ____/_____/_____

SIGNATURE: ____

IF SIGNED BY OTHER THAN CLAIMANT, PRINT BELOW NAME, ADDRESS, AND RELATIONSHIP OF SIGNER.

NAME: ____ RELATIONSHIP: ________________________

ADDRESS:

____

FOR CLINIC USE ONLY

DATE: _____/_____/_____ EMPLOYEE: ____

COMMENTS: ____

CLAIM #: _____________________________ CLAIM ADDRESS: _______________________________________

VERIFIED BY: ____